

Modernization of the Michigan Insurance Code

An overview of House Bills 4933-4935



Our Members

Aetna Better Health of Michigan 1,2,3

Fidelis SecureCare 3

Harbor Health Plan 2

Health Alliance Plan 1,3

McLaren Health Plan 1,2,3

Molina Healthcare of Michigan 1,2,3

Physicians Health Plan 1,2

Total Health Care Plan 1,2,3

Upper Peninsula Health Plan 2,3

Consumers Mutual Insurance of Michigan 1

Grand Valley Health Plan 1

HAP/Midwest Health Plan 2,3

HealthPlus of Michigan, Inc. 1,2,3

Meridian Health Plan 1,2,3

Paramount Care of Michigan 1

Priority Health 1,2,3

United Healthcare Community Plan 1

1 = Commercial Health Plan

2 = Medicaid Health Plan

**3 = Medicare Advantage or
Medicare Special Needs Plan**



MAHP VISION

- *By 2020, Michigan will provide health insurance coverage and options to more than 99% of the State's population.*
- *By fostering competition, by 2020 Michigan will become one of the top 25 competitive states for health insurance. Today, we are third least competitive.*
- *Michigan's Health Plans will work with partners in government, the provider community, community organizations, and business to improve the health status of Michigan residents.*



HB 4933-4935

- Modernize the Insurance Code with respect to health insurance
- Enable faster development of new products
- Keep Michigan laws strong and relevant



Process

- In fall of 2013, MAHP prepared first draft of proposed changes
- Throughout 2014, MAHP:
 - Consulted with interested parties – DIFS, Blue Cross, Agents, Disability Insurers
 - Began conversation with Legislative sponsors
 - Obtained initial official bill draft
 - Participated in workgroups with legislators, DIFS, Blue Cross and others



Process

- 2015
 - Sponsors submitted new bill request
 - Obtained new official bill draft
 - MAHP continued to consult with Legislative Sponsors, interested parties, and DIFS
 - Formal introduction October 1, 2015
 - House Bill 4933 – Patient’s Right to Independent Review Act
 - House Bill 4934 – Coordination of Benefits Act
 - House Bill 4935 – Insurance Code



Current regulation of health insurance in Michigan

- **Chapter 22** – Insurance contracts
- **Chapter 34** – Individual disability coverage
- **Chapter 35** – HMOs
- **Chapter 36** – Group disability coverage
- **Chapter 37** – Small group coverage



Current Regulation (Cont.)

But....

- Mandate language in Chapter 34 also applies to group coverage and HMOs in Chapters 35, 36 and 37
- Definition of “disability insurer” currently includes health insurance, resulting in confusion as to which provisions of Chapter 34 apply to disability and which apply to health
- Chapter 35 restricts innovation in developing health plans desired by employers



General Revisions

- Definition of “health insurance” included in new Section 607
- Chapter 34 specifies which provisions apply to health, which apply to disability, and which apply to both
- Chapter 36 eliminated:
 - Some provisions moved to Chapter 34
 - Unnecessary provisions deleted, including requirement for conversion coverage



General Revisions (Cont.)

- Chapter 35 revised:
 - Provisions that apply to only HMOs remain in Chapter 35
 - Some provisions of Chapter 35 have been revised
 - Provisions that should apply to all health insurers moved to either Chapters 22 or 34

Key Chapter 35 Revisions

- Section 3501 – Some definitions moved to other Chapters
- Section 3503 – HMOs permitted to operate an ASO
- Section 3509 – Service areas not required to be contiguous
- Section 3511 – Medicaid HMO must have either 1/3 of its governing body comprised of enrollees or representatives of membership, or create an consumer advisory board

Chapter 35 Revisions (Cont.)

- Section 3511 – Requirement for election of member representatives by HMO members is eliminated
- Section 3517 – Payment of cash to members allowed if approved by Director. Additional health improvement initiatives allowed.
- Section 3519 – One plan with basic health services must be offered to large employer groups.
- Section 3528 – Credentialing process approved by accrediting agency replaces state requirement



Chapter 35 Revisions (Cont.)

- Section 3537 – Annual open enrollment period eliminated due to guaranteed issue requirement of ACA
- Section 3539 – Guaranteed renewal doesn't apply if employer fails to meet minimum contribution requirements
- Section 3544 – New section will allow HMOs to process claims for noninsured benefit plans, but only after HMO has received funds to cover claims payment

Key Chapter 34 Revisions

- Sections clarified as to whether they apply to health insurance, disability, or both
- Section 3405 – Removed requirement for insurers and HMOs to offer indemnity plans
- Section 3406k – Adds definition of “prudent layperson” for coverage of emergency services
- Section 3406o – Adds expedited process for approval of experimental drugs



Chapter 34 Revisions (Cont.)

- Section 3409 – Addresses issue when a person signs up for policy, never pays premium, but received services
- Section 3425 – Eliminates minimum dollar coverage for substance use disorder services
- Section 3426 – Permits rebate for tobacco cessation programs to be equal to 50% of premium; allows insurers to develop new products in response to market demand



Chapter 34 Revisions (Cont.)

- Section 3452 – Coverage excluded for illegal activities that include driving with a blood alcohol level in excess of the legal limit or operating a so-called “meth lab”
- Section 3474 – Incorporates Sections 2242 and 3525. Director has 60 days to approve individual or small group rates and forms, and 30 days for other forms and rates. If Director withdraws approval of a rate of form, insurer may continue to use it until appeal is completed

Chapter 34 Revisions (Cont.)

Section 3474a – Incorporates language from Section 3517 regarding development of rates for large groups

Sections 3477 – Current Section 3542, which prohibits payment by HMO of an inducement to health professionals, moved to Chapter 34 to apply to all insurers



Key Chapter 22 Revisions

- Section 2213 – Informal grievance procedure revised to conform timelines with federal ERISA law and to incorporate federal definition of adverse determination
- Section 2236 – Readability scoring clarified, new subsection (8) allows delivery of documents electronically under certain conditions

PRIRA and COB Revisions

- Coordination of Benefits (HB 4934):
 - Adopts NAIC Model Act
 - Will reduce conflict when coordinating with national carriers. If insurers cannot agree as to which plan is primary, both pay equal amounts, but no more than what they would have paid if primary
 - Required Director to promulgate rules to implement the Act
- Patient Right to Independent Review Act (HB 4933):
 - Updated to reflect changes in federal laws, which permit Michigan to operate appeal process
 - Changes deadline for filing from 60 days to 120 days
 - Adds requirement for IROs to be accredited



Questions?

